EXHIBIT “A”

Millennium Health Care of Clifton
925 Clifton Ave
Clifton NJ

Date: 10/14/13
Patient: [redacted], **Katherine**
Procedure: Left L3-4 Transforaminal Epidural Steroid Injection under Fluoroscopy
Surgeon: Pamela D'Amato, MD
Preop Diagnosis: HNP, Left Lower extremity Radiculitis
Postop Diagnosis: Same
Anesthesia: Local

INTERIM HISTORY:

The patient was evaluated and examined before the procedure and has no contraindication for the proposed procedure.

PROCEDURE NOTE:

After obtaining a written informed consent the EKG, NIBP and Pulse Oximeter were applied and the patient was monitored throughout the procedure. The patient was positioned prone. The lumbosacral area was prepared and draped in a sterile fashion.
Using fluoroscopy, the L3 vertebral body and left pedicle were identified. The skin and subcutaneous tissues above the L3 were infiltrated with a 25 g 1 ½ inch needle and 3ml of 1% Preservative Free Lidocaine. Under fluoroscopic guidance, a 22-gauge 5 inch spinal needle was advanced to 6:00 position of the pedicle on fluoroscopy, in AP and lateral views. The needle was advanced into the epidural space. After negative aspiration, 1 ml of Omnipaque 240 was injected. AP and lateral fluoroscopic views confirmed a satisfactory spread of the dye towards the midline as well as along the exiting nerve root. Then 1 ml of 0.25% Preservative Free Bupivicaine and 40 mg of Depomedrol were then injected at both levels. The needles were removed; Bacitracin ointment was applied to the site of the needle insertions and covered with Band-Aid.
The patient tolerated the procedure well and discharged home in a stable condition with no apparent short-term complications.

PLAN:

The patient will continue the same current medications, activity as tolerated and will return for a follow up office visit in two weeks as needed.

PD'Amato

Pamela D'Amato, MD

Millennium Health Care of Clifton
925 Clifton Ave
Clifton NJ

Date: 12/30/13
Patient: [redacted] **Katherine**
Procedure: Left L3-4 Transforaminal Epidural Steroid Injection under Fluoroscopy
Surgeon: Pamela D'Amato, MD
Preop Diagnosis: HNP, Left Lower extremity Radiculitis
Postop Diagnosis: Same
Anesthesia: Local

INTERIM HISTORY:

The patient was evaluated and examined before the procedure and has no contraindication for the proposed procedure.

PROCEDURE NOTE:

After obtaining a written informed consent the EKG, NIBP and Pulse Oximeter were applied and the patient was monitored throughout the procedure. The patient was positioned prone. The lumbosacral area was prepared and draped in a sterile fashion.
Using fluoroscopy, the L3 vertebral body and left pedicle were identified. The skin and subcutaneous tissues above the L3 were infiltrated with a 25 g 1 ½ inch needle and 3ml of 1% Preservative Free Lidocaine. Under fluoroscopic guidance, a 22-gauge 5 inch spinal needle was advanced to 6:00 position of the pedicle on fluoroscopy, in AP and lateral views. The needle was advanced into the epidural space. After negative aspiration, 1 ml of Omnipaque 240 was injected. AP and lateral fluoroscopic views confirmed a satisfactory spread of the dye towards the midline as well as along the exiting nerve root. Then 1 ml of 0.25% Preservative Free Bupivicaine and 40 mg of Depomedrol were then injected at both levels. The needles were removed; Bacitracin ointment was applied to the site of the needle insertions and covered with Band-Aid.
The patient tolerated the procedure well and discharged home in a stable condition with no apparent short-term complications.

PLAN:

The patient will continue the same current medications, activity as tolerated and will return for a follow up office visit in two weeks as needed.

Pamela D'Amato, MD

Millennium

REPORT OF OPERATION

Patient's Name:	Katherine [redacted]
Patient No.:	00322-13
Date of Surgery:	01/19/2016

PREOPERATIVE DIAGNOSES:

1. Lumbar disc herniation at L3-4,
2. Left lumbar radiculopathy,
3. Painful left-sided lumbar spinal hardware, status post posterior spinal fusion L4-S1.

POSTOPERATIVE DIAGNOSES:

1. Lumbar disc herniation at L3-4,
2. Left lumbar radiculopathy,
3. Painful left-sided lumbar spinal hardware, status post posterior spinal fusion L4-S1.

PROCEDURES PERFORMED:

1. Posterior interlaminar decompression laminectomy at L3-4,
2. Foraminotomy at left L3-4,
3. Lumbar epidural steroid injection at L3-4,
4. Removal of deep spinal hardware L4-S1,
5. Use of microscope and microscopic technique,
6. Use and interpretation of fluoroscopy.

Surgeon:	Ki Hwang and Kumar Sinha, M.D.
Assistant:	[redacted].
Anesthesiologist:	Talitha Burns, DO.
Type of Anesthesia:	General with endotracheal intubation.
Complications:	None.
EBL:	Min.
Specimen sent:	None.
Findings:	Lumbar spinal stenosis.
Disposition:	The patient tolerated the procedure well and was taken to the post-anesthesia recovery room in stable condition.

INDICATIONS: This 57-year-old woman who underwent uncomplicated anterior and posterior spinal decompression and fusion 2013 presents to my office complaining of worsening lower back pain on the left

side with radiating pain to left leg. In the past, the patient was successfully treated with lumbar transforaminal epidural injection for radicular symptoms. Unfortunately, her condition progressed despite going recent injections. She has a failed conservative treatments, the patient was indicated for surgical intervention. Risks, benefits, alternatives to surgical intervention were discussed with the patient. She understands issues involved and would like to proceed with the surgery.

DESCRIPTION OF PROCEDURE: The patient was taken to the operating room and placed under general endotracheal anesthesia. The patient was placed in a prone position over a radiolucent table. All bony surfaces carefully padded to prevent any position related neurapraxia.

The patient's posterior aspect of the lower back was prepped and draped in the usual sterile manner. Fluoroscopy was brought into the surgical field and was able to find the previously placed spinal instrumentation on the left L4 and S1 segments.

Using previous surgical incisions, I made an incision in along the longitudinal manner over the L4 and S1 pedicles. Sequential dilation of the soft tissue was performed until is able to identify the locking cap. The locking cap was then removed. Each of the procedure was repeated both L4 and S1 screws. A specific, connecting rod was removed. I then placed cannulated guidewire. Over these guidewires, I was able to remove the pedicle screws from L4 and S1 pedicles. At this stage complete and thorough hemostasis obtained. Wound was copiously irrigated with normal sinus solution.

The wound was then closed meticulously reapproximated. The fascia was sutured with #1 Vicryl followed by 2-0 Vicryl.

I then turned my attention to laminectomy and posterior decompression. I identified the L3-4 disc space by placing an 18-gauge spinal needle under the fluoroscopy guidance.

A posterior approach to lumbosacral spine was utilized. A longitudinal incision, measuring approximately 15 mm was made over the L3-4 segment. The incision was made sharply using a #10 blade. Dissection was then carried down sharply down to deep dorsal lumbosacral fascia. The fascia was then incised. The paraspinous musculature was sequentially dilated using a tubular blunt dissecting system. Dilation of the paraspinous muscle was performed and pushed away revealing the interlaminar space at the L3-4. A

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probe was inserted underneath the lamina and confirmatory fluoroscopy image was obtained.

Remaining soft tissue was cauterized and removed with pituitary and Kerrison rongeurs and the interlaminar space was then identified. At this point, the microscope was brought into the field. Under the direct microscopic visualization, I proceeded to perform the laminectomy at the L3-4.

A high-speed drill was utilized to remove the inferior aspect of the lamina at L3 and the superior aspect of the lamina at L4. A laminectomy at the L3-4 was created and the ligamentum flavum was gently elevated off using 1 and 2 mm Kerrison punches. The thecal sac was then visualized along with the exiting nerve roots.

We then proceeded with the completion of decompression by performing foraminotomy. The traversing and exiting nerve roots were identified and followed and skeletonized. Upon completion of the procedure, the traversing and exiting nerve roots were thoroughly decompressed.

FloSeal was injected into the epidural space to obtain hemostasis. 40 mg of Depo-Medrol was injected into the epidural space, thus performing epidural injection. At this stage, the microscope was moved away.

After obtaining thorough hemostasis, the wound was copiously irrigated with normal saline solution. The deep fascia was then reapproximated with #1 Vicryl absorbable sutures. The subcutaneous tissue was closed with 2-0 Vicryl in an interrupted manner. Finally, the skin was closed with 3-0 Monocryl subcuticular suture in running manner. Dry sterile dressing was applied.

The patient was then turned back to supine position and he was extubated promptly without complications.

PHYSICIAN SIGNATURE _____

Ki S Hwang, MD

Millennium Health Care of Clifton
925 Clifton Ave
Clifton NJ

Date: 4/4/16
Patient: [redacted] **Katherine**
Procedure: Bilateral Sacroiliac Joint Injections under Fluoroscopy
Surgeon: Pamela D'Amato, MD
Preop Diagnosis: Right Sacroilitis
Postop Diagnosis: Same
Anesthesia: Local

INTERIM HISTORY:
The patient was evaluated and examined before the procedure and has no contraindication for the proposed procedure.

PROCEDURE NOTE:
After obtaining a written informed consent the EKG, NIBP and Pulse Oximeter were applied and the patient was monitored throughout the procedure. The patient was positioned prone. The lumbosacral area and right sacroiliac joint area were prepared and draped in a sterile fashion. Using fluoroscopy, using fluoroscopy, the most inferior end of the right sacroiliac joint was identified and the skin and soft tissue were infiltrated with 4 ml of Lidocaine 1%. Using a BD 3.5 needle was directed to that point.
Using fluoroscopy, using fluoroscopy, the most inferior end of the left sacroiliac joint was identified and the skin and soft tissue were infiltrated with 4 ml of Lidocaine 1%. Using a BD 3.5 needle was directed to that point.
1 ml of Omnipaque 240 was injected resulting in a satisfactory arthrogram of both joints. After negative aspiration, a total of 3.5 ml of 0.25% Bupivicaine and 40 mg of Depomedrol were injected to the joint without complication. The needles were removed; Bacitracin ointment was applied to the site of the needle insertions and covered with Band-Aid.
The patient tolerated the procedure well and discharged home in a stable condition with no apparent short-term complications.

PLAN:
The patient will continue the same current medications, activity as tolerated and will return for a follow up office visit as needed.

Pamela D'Amato, MD